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Rapid-Improvement Support and Exchange

Ontario Health Teams & Population Health Management: a Recap from the OHT Forum

RISE OHT Webinar

March 12, 2020

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Welcome!

Why does population health management matter to OHTs?

- OHT model shifts from reactively providing care to the people who walk though the doors of our health system

To

- Proactive health promotion, prevention, treatment and care for a whole population

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Acknowledgements and Caveats

- RISE provides evidence-based support to OHTs, using a 'rapid learning and improvement' lens, as part of the ministry's OHT Central Program of Supports
- RISE prepares both its own resources (like RISE briefs) that can support rapid learning and improvement, as well as provides a structured 'way in' to resources prepared by other partners and by the ministry
  - RISE is supported by a grant from the Ontario Ministry of Health
  - The opinions, results, and conclusions – both those conveyed in our resources and at events like this one – are those of RISE and are independent of the ministry
  - No endorsement by the ministry is intended or should be inferred

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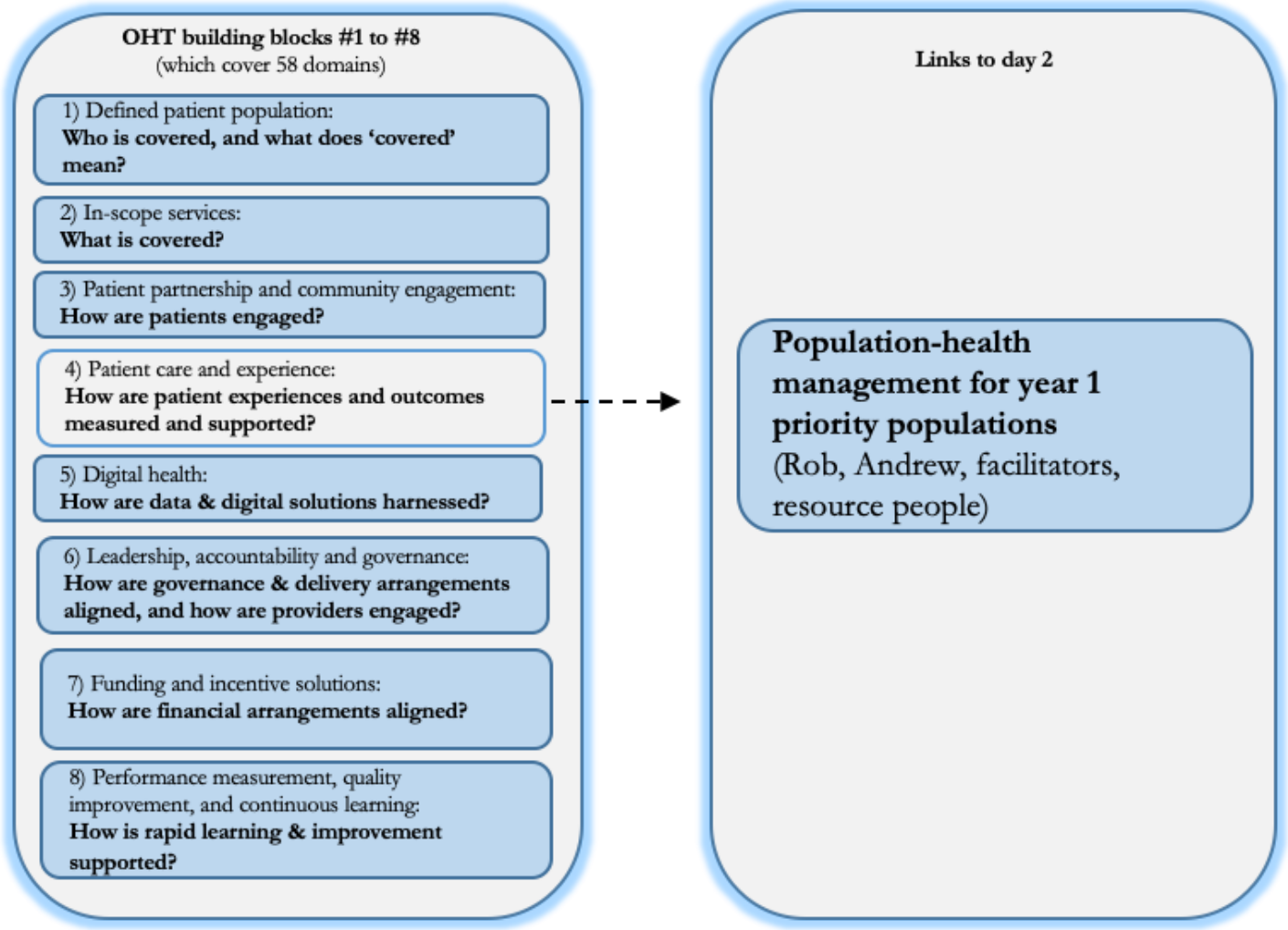
Connection to Building Blocks



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Population Health Management

- A central challenge for OHTs is to **integrate** & **manage** the continuum of health services for a **defined population** of patients
- OHT populations reflect prior care seeking & referral patterns (**attributed population**)
- For these defined populations, the **goals are to**:

Population Health – A Definition

"The **health outcomes** of a **group** of individuals, including the **distribution** of such outcomes within a group."

Kindig & Stoddart. AJPH 2002;93(3):380-3

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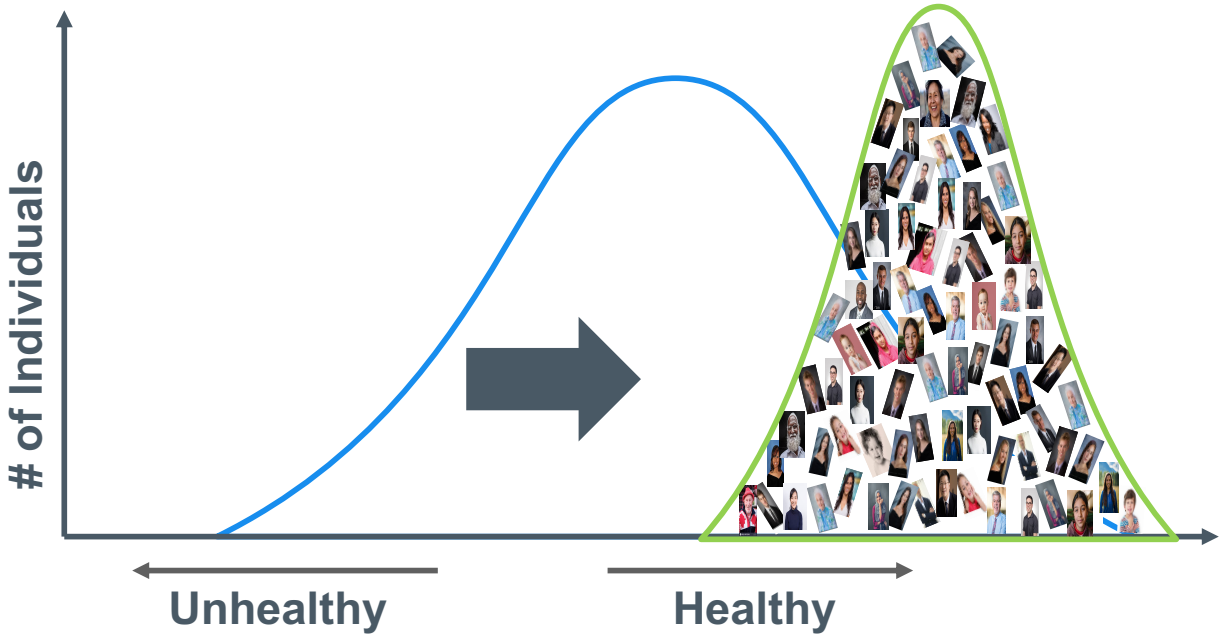
Population Health – A Definition

Population-wide strategies to **shift and squeeze the curve** to improve overall population health and reduce inequities



"LEAVE NO ONE BEHIND" & TACKLE THE "INVERSE CARE LAW"

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Determinants of Health in Populations

AREAS OF FOCUS FOR OHTS

WHAT MAKES PEOPLE SICK?		
11%	HEALTH CARE	Access to quality illness-related and preventive care, continuity of care, chronic care self-management
60%	SOCIAL CIRCUMSTANCES & HEALTH BEHAVIOURS	Income, early childhood development, disability, education, social exclusion, social safety net, gender, employment / working conditions, race, aboriginal status, safe and nutritious food, housing / homelessness, community belonging
22%	BIOLOGY	Biology, genetics
7%	ENVIRONMENT	Air &water quality, civic infrastructures

Adapted from: determinantsofhealth.org

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A Population Health Approach…

Identifies **systemic variations & patterns** in health & care

Focuses on the **conditions & factors** that are related & influence the health of populations

Develops services & policies to improve the health & well-being of populations

Implementation can be at the **individual or population** level

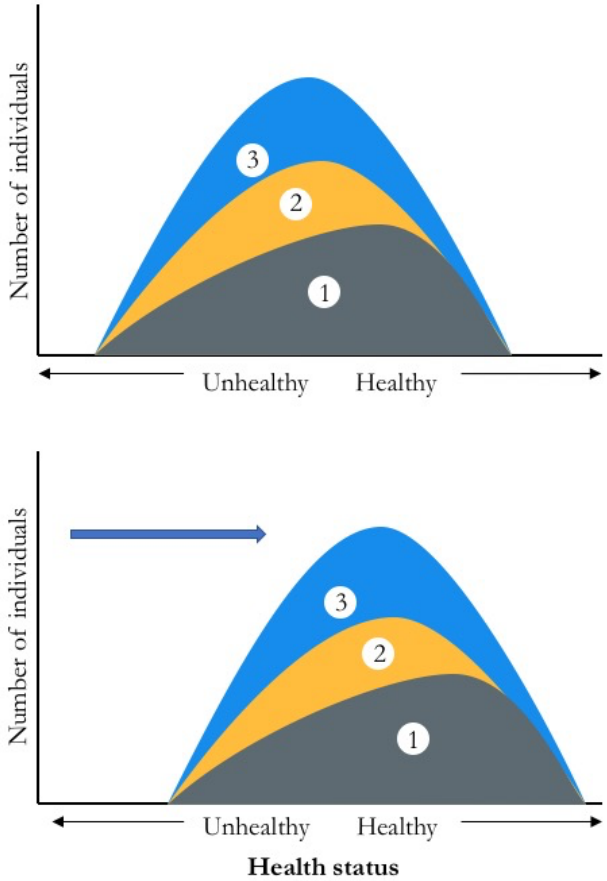
Developing OHT Population Health Strategies at the Level of the Individual & Population

EXAMPLES:

POPULATION	INDIVIDUAL-LEVEL SERVICE	POPULATION-LEVEL POLICY/PROGRAM
PERSONS NEARING END-OF-LIFE	Palliative care programs	Educational campaigns on advance care planning & powers of attorney
FRAIL OLDER ADULTS	Programs of All-inclusive Care for the Elderly (PACE)	Age-friendly transportation options, built environment initiatives
PERSONS WITH DIABETES	Systematic screening & diagnosis, self-management support programs	Diet & physical activity promotion programs

Role of Health Care in Producing Population Health:

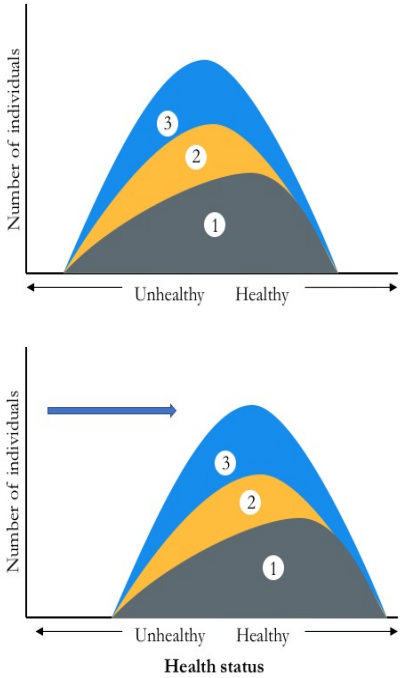
"Shifting the 3 curves"



1. Patients seeking care from OHT partners
2. OHT population that is the focus of in-reach and out-reach approaches
3. Entire population of the community that would be affected by population-based approaches

Source: Washington AE et al. JAMA 2016 315(5); 459-460

Role of Health Care in Producing Population Health

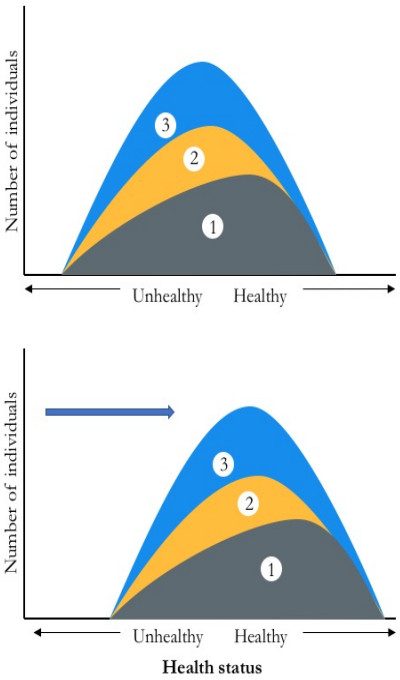


❶ 1st Curve – Care for Acute Health Problems

- Timely access to high-quality acute care services
- Oriented around care episodes (e.g. visits, hospitalizations)
- Reacts to individual patient needs, not populations
- Population health impact comes through users one-by-one (e.g. high-quality care for acute stroke)

"SUSTAIN THE GAINS"

Role of Health Care in Producing Population Health



❷ 2nd Curve – Clinical Population Health Management

- Proactive management of chronic conditions & behavioural risks
- Population is segmented to identify persons with common needs
- Uses an equity lens & addresses barriers
- Interventions are individually focused & proactively applied
- Apply "good clinical care" consistently to everyone across population segments

"NEW FOCUS FOR OHTS"

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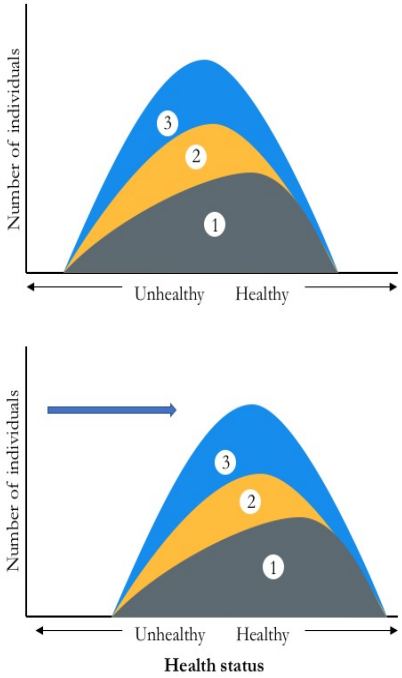
Role of Health Care in Producing Population Health



❸ 3rd Curve – Population Policies & Interventions

- Focus is non-medical determinants of health
- Oriented longitudinally over the lifespan across large populations
- Health care community's role can be to provide, facilitate or advocate

"FUTURE FOCUS FOR OHTS
DEEPEN PARTNERSHIPS WITH LOCAL GOVT & COMMUNITY ORGS"

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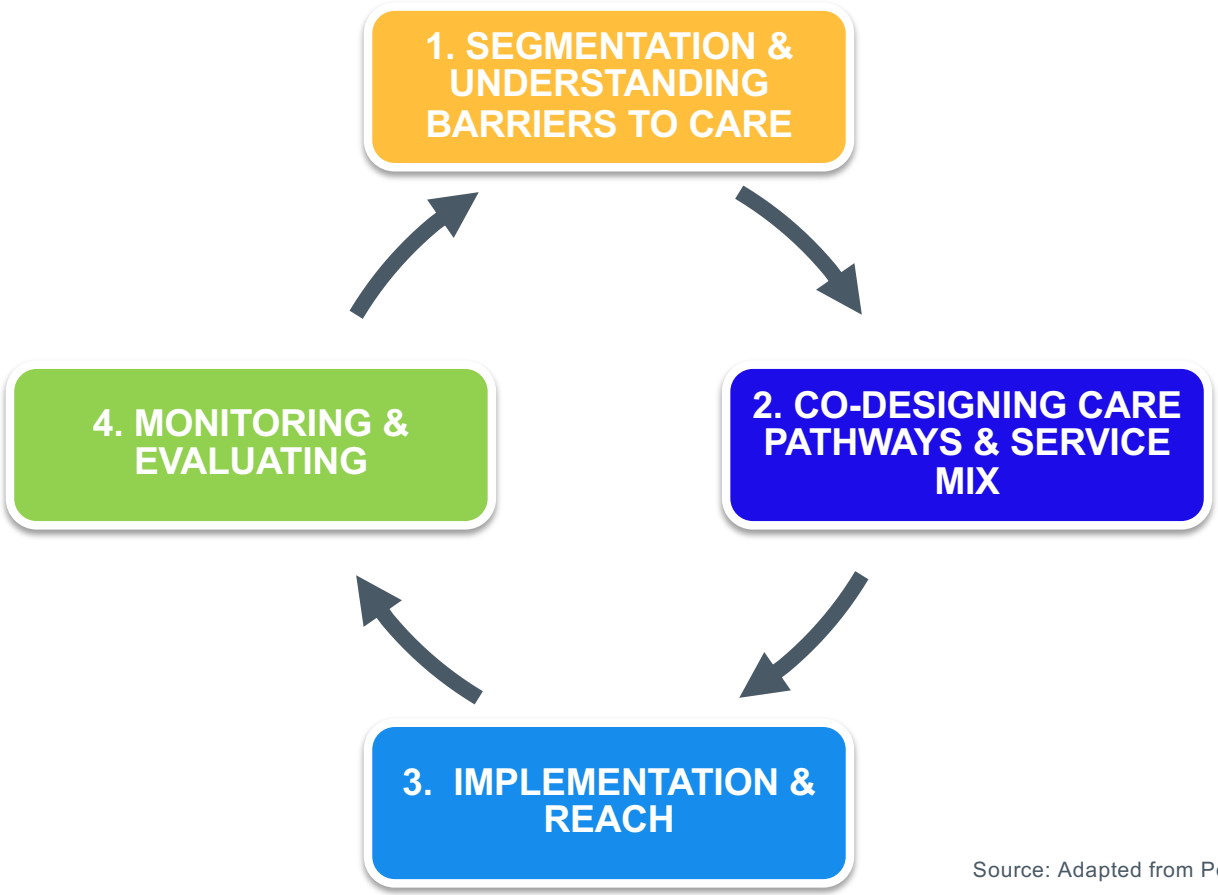
4 Steps of Population Health Management: the Second Curve



Source: Adapted from Population Health Alliance, 2012

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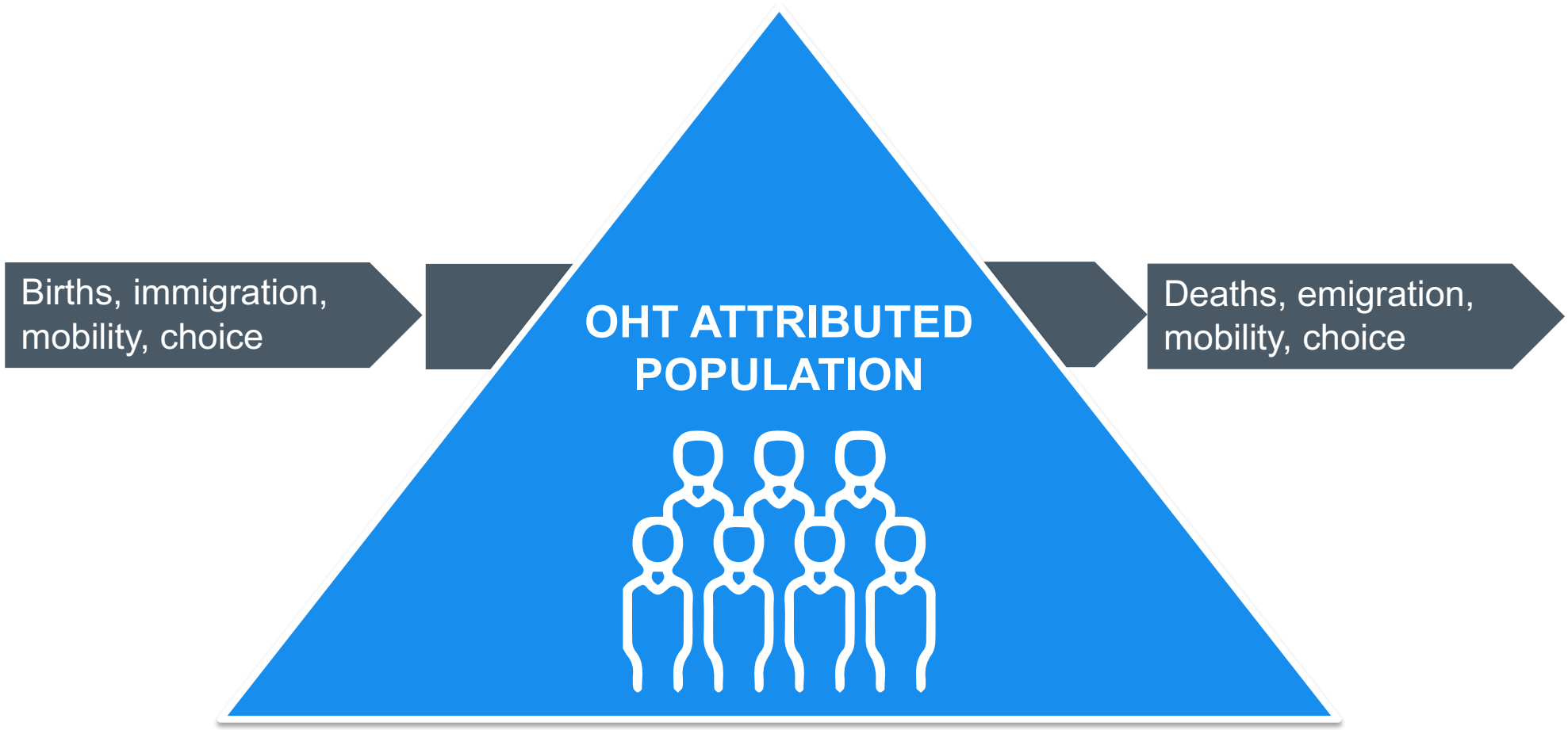
OHTs & Their Attributed Populations

Population is Continually Evolving



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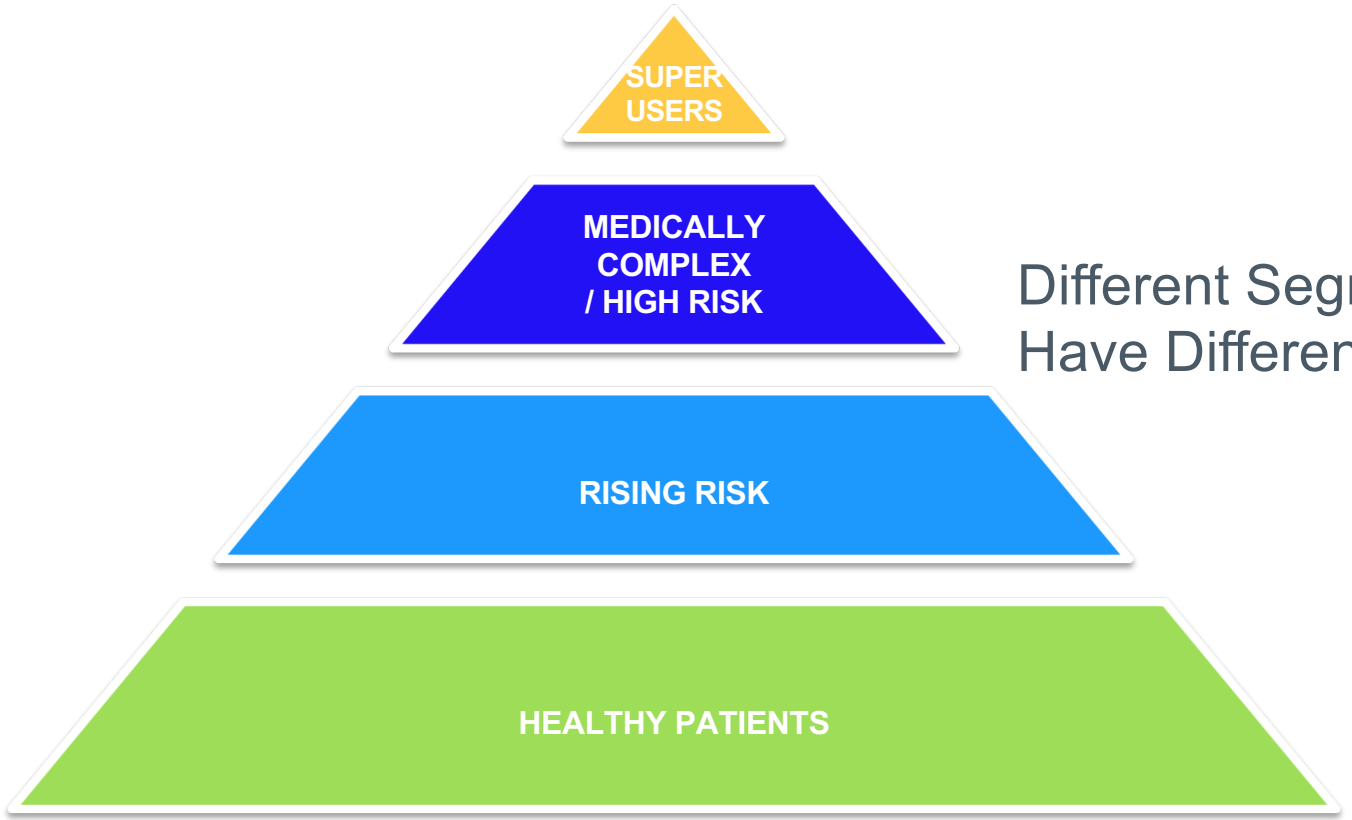
Step 1: Population Segmentation & Understanding Barriers to Care

Kaiser Risk Pyramid



Different Segments Have Different Needs

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Step 1: Population Segmentation & Understanding Barriers to Care

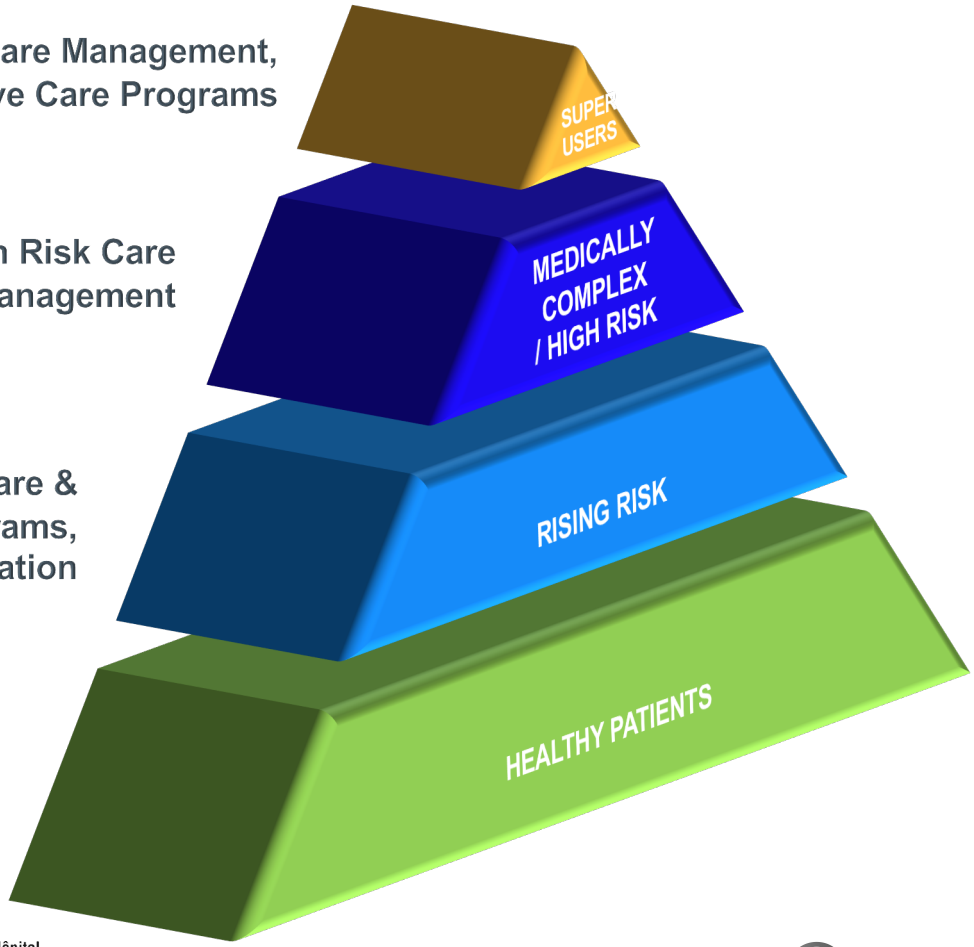
Health Programs & Interventions

High Risk Care Management, Palliative Care Programs

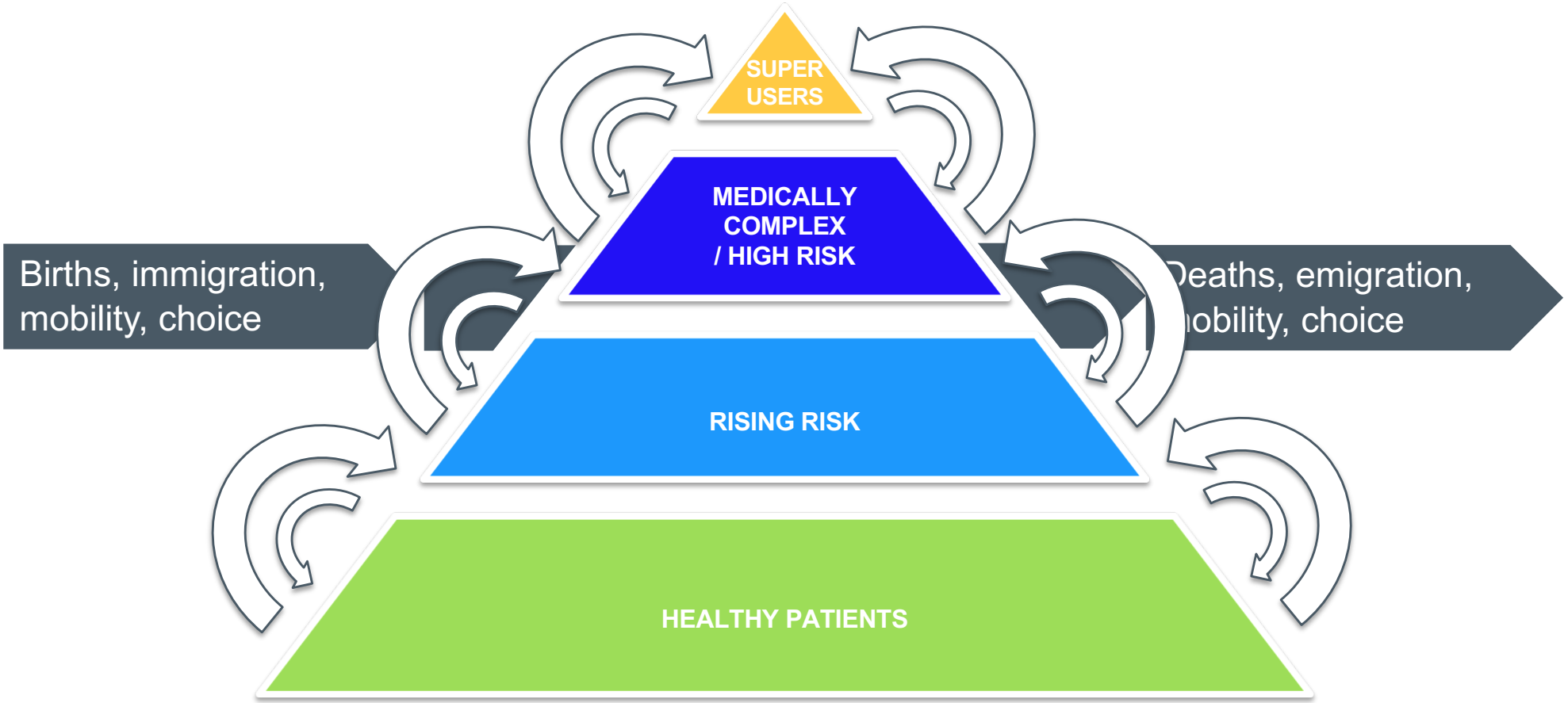
High Risk Care Management

Chronic Illness Care & Collaborative Care Programs, Care Coordination

Engagement, Screening & Counselling Navigation



Step 1: Population Segmentation & Understanding Barriers to Care



Population Segments are Continually Evolving

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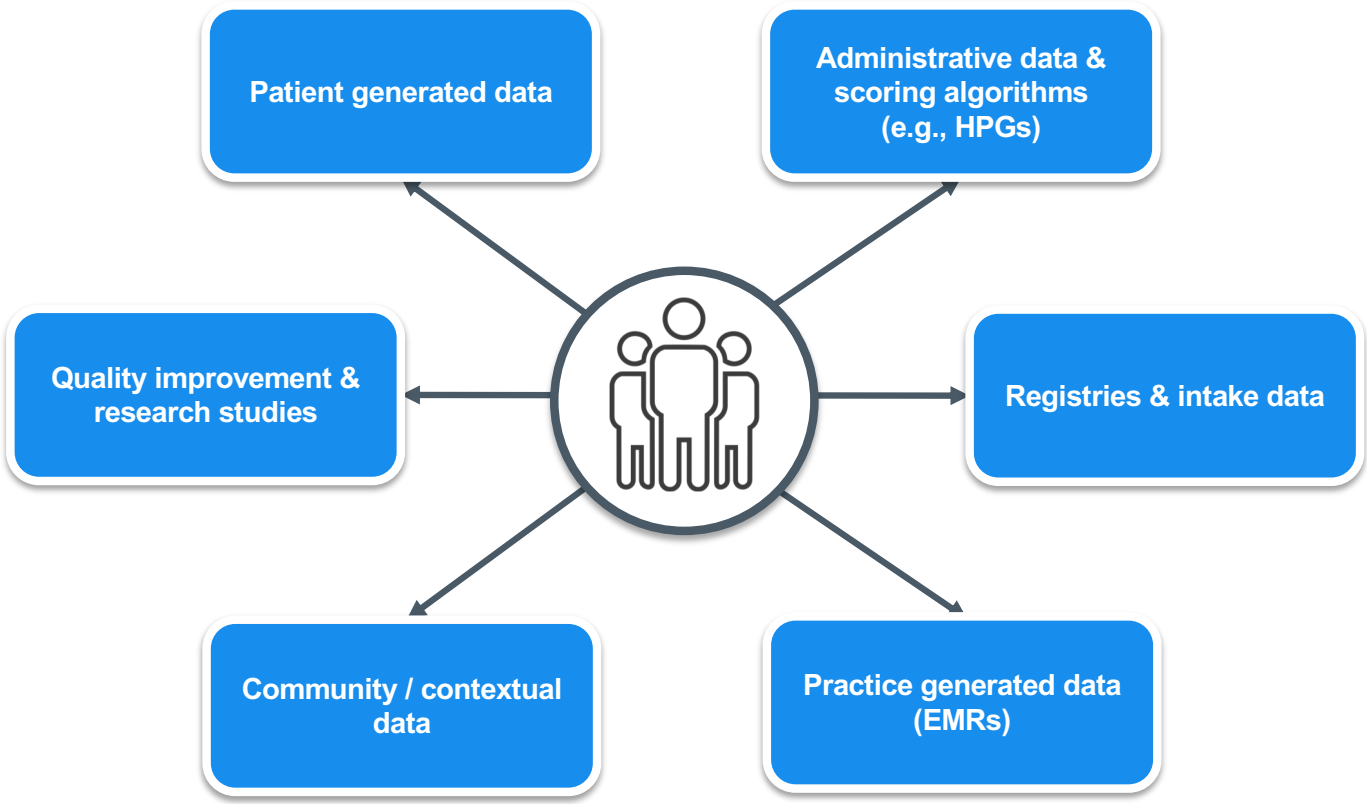
Step 1: Population Segmentation & Understanding Barriers to Care

Data Sources



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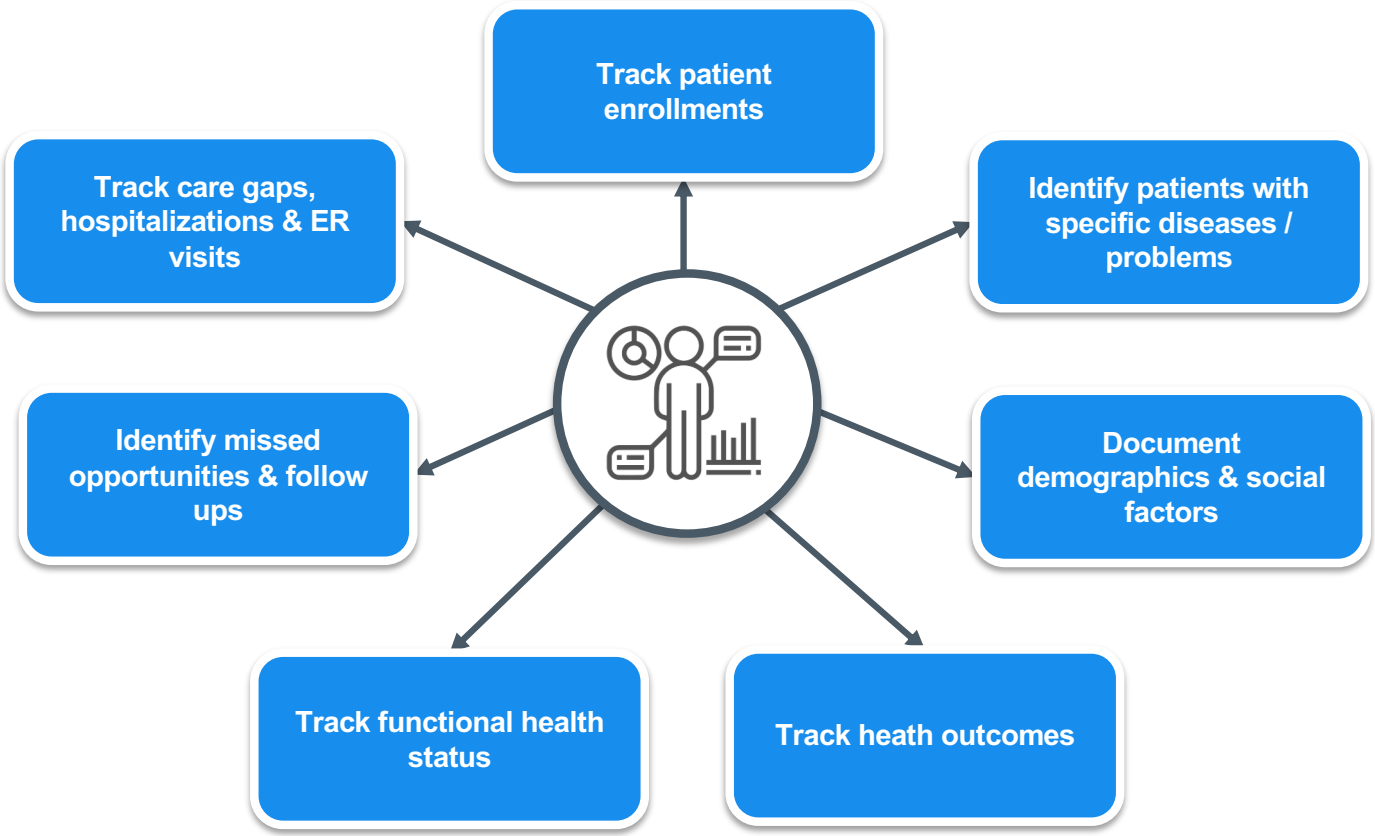
Step 1: Population Segmentation & Understanding Barriers to Care

Using the EMR to Document, Track, & Prompt



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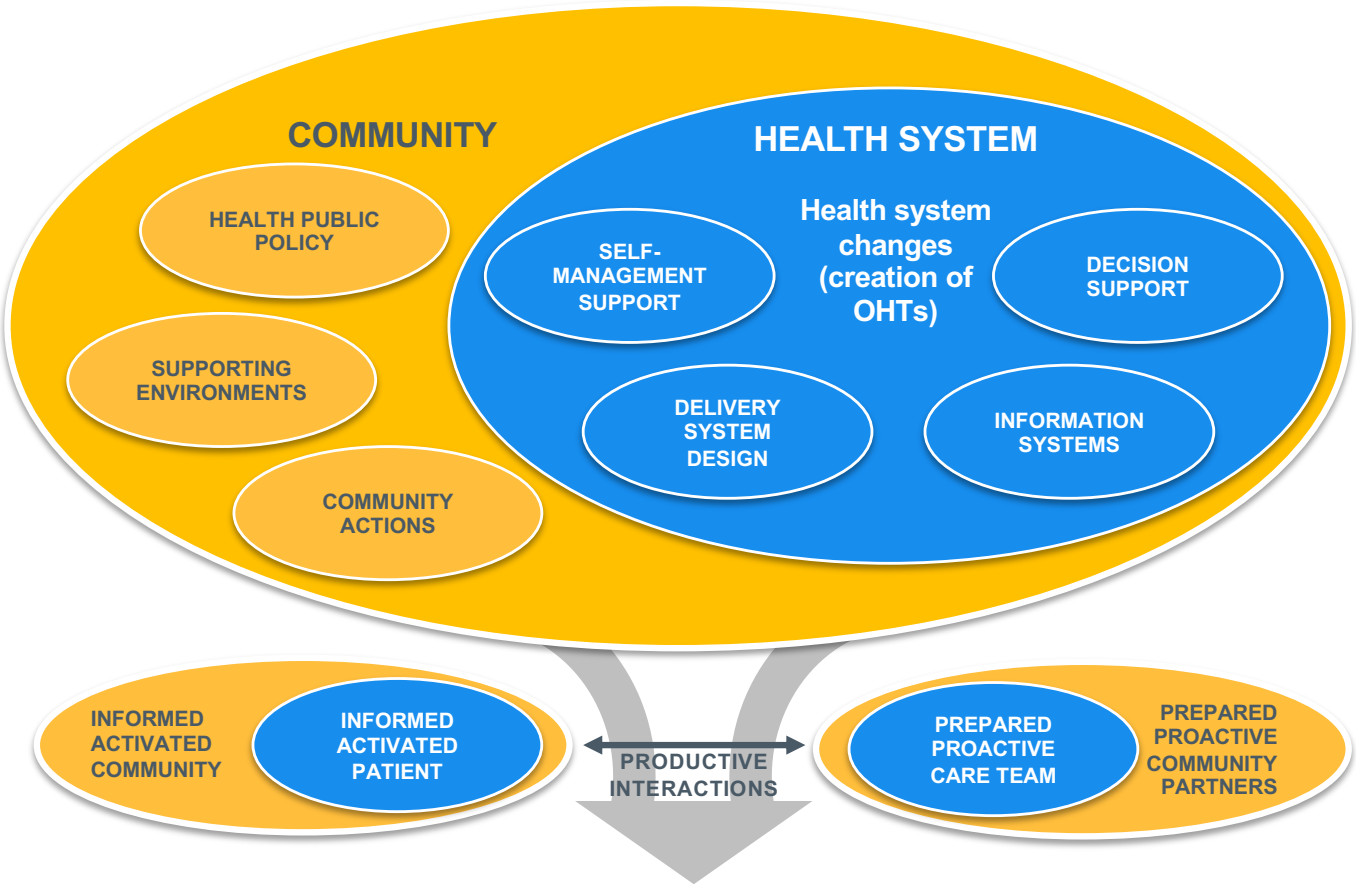
Step 2: Co-designing Care Pathways & Service-mix

Expanded Chronic Care Model for Population Health



Adapted from:
Barr VJ et al. Healthcare Q 2003:7(1):73-82.
Wagner EH et al. Milbank Quarterly 1996; 74(4): 511-44.

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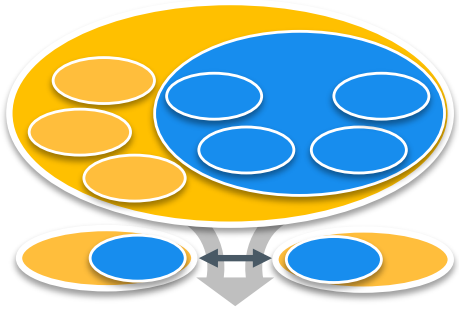
Step 2: Co-designing Care Pathways & Service-mix



- **Delivery System Redesign**
  - **New roles** & **new tools** across OHT
  - **In reach** and **outreach** functionalities (often virtual)
  - **Care coordination** functions & use of **care management**
  - Mechanisms to identify & address **barriers to care**
- **Clinical Decision Supports**
  - Agreed upon **clinical pathways** & **practice guidelines**
  - Active use of **prompts** & **reminders** for providers & patients
- **Clinical Information Systems**
  - Population **registries** & patient-centred **trackers** for care & outcomes
- **Patient Self-Management Support**
  - Interventions to build **motivation**, **skills**, **capabilities** for **behaviour change**

Step 3: Implementation & Reach

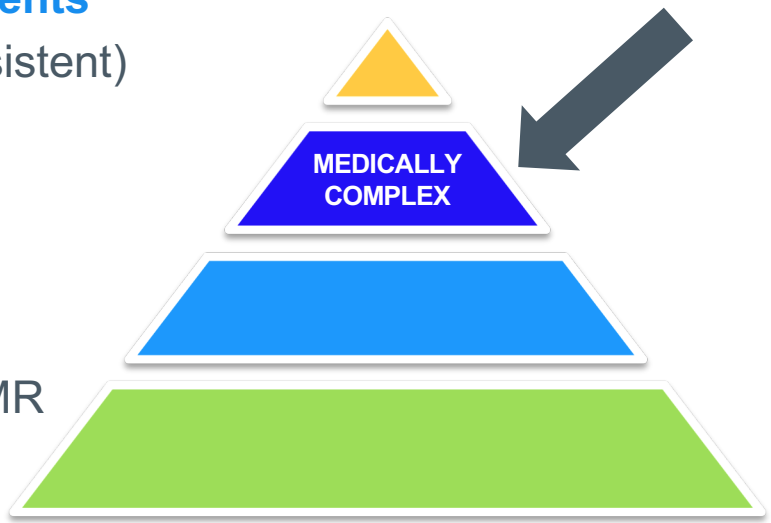
- Develop an initial program logic model, that connects inputs, activities and short-term and long-term outcomes
- Pilot test new care pathways, tools and approaches with a small number of patients, over a short period of time
  - Focus on implementation, getting quick feedback from patients and providers
- Increase reach gradually, keeping track of what proportion of a priority population the new pathway, tool or approach is reaching, over what period of time

Step 4: Monitoring & Evaluation

- Revise program logic model based on your initial work
- Include ongoing monitoring and evaluation, including both the number of patients who are served and the impact, at an individual-level and system-level
- Choose outcomes that are clinically relevant, measurable as part of routine care, and can be extracted easily from EHRs
- Feed findings back to OHT leadership, and share with others who are serving the same priority population

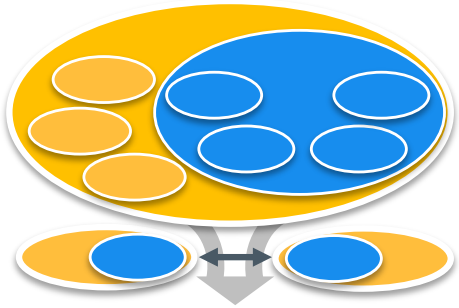
Example: High-risk Case Management Program at Partners Healthcare

- **High-risk care management program** embedded within primary care
- Focuses on **chronically ill**, **medically complex patients**
  - ✓ Multiple chronic illnesses (some severe and persistent)
  - ✓ Mental health or substance abuse complicating medical conditions
  - ✓ SES factors complicating medical management
- Predictive risk score used to **segment & identify population**, **supplemented by social risks** from EMR
- **Enrollment confirmed** by primary care clinicians



Source: Amy Flaster, MD MBA, Center for Population Health, Partners Healthcare

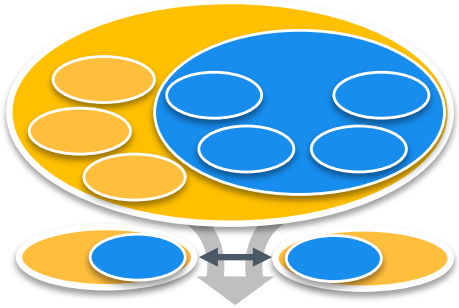
Example: High-risk Case Management Program at Partners Healthcare



- **Delivery System Redesign**
  - Care manager with roster, embedded in primary care
  - Use of home visits, tele-monitoring, virtual care, post-acute integration
- **Clinical Decision Supports**
  - Structured care plans, goals of care conversations, case reviews
  - Ongoing support & training for teams & staff
- **Clinical Information Systems**
  - Registries & care coordination tools
  - Real-time notifications of admissions & discharges
- **Patient Self-Management Support**
  - Health coaching & shared-decision making tools

Source: Amy Flaster, MD MBA, Center for Population Health, Partners Healthcare

Example: High-risk Case Management Program at Partners Healthcare



- **Care Manager** has panel of patients with target panel size
  - Medical complexity – RN Lead
  - Psychosocial complexity – social worker lead
  - Community/social complexity – community health worker lead
- **Responsible for…**
  - Patient assessment (risks, gaps)
  - Care plans and systematic case reviews
  - Care coordination, communication, transition planning
  - Goals of care conversations, self-management support
- Supported by **community resource specialist**, **pharmacist**

Source: Amy Flaster, MD MBA, Center for Population Health, Partners Healthcare

Some of What We Heard at OHT Forum

Step 1. Segmenting population into groups with shared needs

- Variable experience in working at the population level
- Common challenges:
  - Where to start with palliative care?
  - Focus on single vs across chronic conditions?
  - How to integrate physical, mental and social issues?
- Need help with access to data (deidentified and identifiable), both quantitative and qualitative
- Need help with interventions to address social needs

NB: Upcoming RISE brief on population health management

Some of What We Heard at OHT Forum

Step 2. Co-designing care pathways and in-reach/out-reach services

- Variability in capacity for and experience with patient partnership to co-design
- Balance provincial initiatives and local context
- Complementing representation with meaningful co-design ‘on the ground’
- Keep focus on equity and patient voices
- Add self-management supports

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Some of What We Heard at OHT Forum

Step 3. Implementing pathways/services in a way that reaches and is appropriate to groups

- Not everyone is at the point of implementation
- Common barriers relate to data sharing and physician engagement

Some of What We Heard at OHT Forum

Step 4. Monitoring implementation and evaluating impact

- Need coordination to share data, logic models, performance metrics, outcome measures/performance metrics, and evaluation tools
- Common commitment to 'moving the needle,' especially with patient and provider experiences

NB: Upcoming RISE session on logic models

Summary

- Population health thinking is **new** & **challenging** for most people.
- Operating in a **resource constrained environment**. Will need to shift efficiently shift care among partners among partners.
- **Selecting** & **transitioning** populations is **key, but tricky**.
- Building **better data** & **analytic capacity** for planning & care. But avoid paralysis.
- Holding each other **accountable** in the application of **care pathways**.
- Focusing on **clinical population health strategies first**, followed by broader population-based strategies.

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Questions?

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English: **www.OHTrise.org** | Français: **www.ESOrise.org**

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Join RISE for upcoming webinars

- Four webinars about resources to support population-health management – one for each year 1 priority population – have been scheduled
  - People who would benefit from a palliative approach to care:
    Webinar on Tuesday 17 March from 12-1 pm
  - People with mental health and addictions issues:
    Webinar on Tuesday 24 March from 12-1 pm
  - People with chronic conditions:
    Webinar on Monday 30 March from 12-1 pm
  - Older adults with greater needs
    Webinar on Tuesday 31 March from 12-1 pm

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More webinars to join & new resources coming soon

- OHT Central Program of Supports: Tuesday 7 April from 12-1 pm
- Primary-care physician engagement: Tuesday 14 April from 12-1 pm
- Data sharing within existing rules: Tuesday 21 April from 12-1 pm
- Insights for provincial health-system partners about balancing provincial guidance and local contextualization and transitioning to high-value data collection: Tuesday 28 April from 12-1 pm

- Prepare or update RISE briefs about population-health management, four priority populations, and building blocks (e.g., overall; data-analytics platform; population segmentation), and key patient partner, health-system partner and research partner resources (e.g., OHT Central Program of Supports; OH's Quality Business Unit)

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